Rape and Domestic Violence: The Experience of Refugee Women

Amy R. Friedman

SUMMARY. Despite the fact that women and girls make up over half of the world's 18 million refugees, little attention or resources have been dedicated to meeting their needs. Although all refugees face health and protection problems, women are susceptible to additional problems as a result of their gender. Women and girls who flee their home countries to escape violence and persecution are particularly vulnerable to sexual violence. Rape is a common experience for refugee women, and the resulting trauma has life altering affects for both the women and their families. Often male refugees suffer from "heightened male vulnerability" as a reaction to witnessing torture, violence or rape. This, combined with the additional stress of resettlement in a new culture, often leads male refugees to resort to domestic violence as a way of reestablishing control and gaining power. Since refugee women are the pillars of their families, domestic violence and rape trauma present serious obstacles to the self-sufficiency of refugee families. It is the responsibility of health care providers in both the international community and in countries of resettlement to significantly address sexual violence and its repercussions on the successful resettlement of refugees.

INTRODUCTION

More than 18 million refugees in the world today have left their homes and fled for their lives leaving behind war, persecution, or internal conflicts.[1] It has been estimated that 75% of the total refugee population consists of women and girls (Overhagen, 1990, p.3), and in some regions

Amy R. Friedman is currently Administrative Assistant/Bookkeeper at Refugee Women in Development (RefWID), Inc., Washington, DC. She has a BA in Sociology with a Program in Women's Studies from Brandeis University.

women comprise a greater majority of the refugee population. According to Sima Wali, Executive Director of Refugee Women in Development (RefWID) in Washington, D.C., women and girls comprise 80% of the more than 5 million Afghan refugees who fled from the recent Soviet invasion.

Women are not only found in disproportionate numbers, but often find themselves with sole responsibility for large families after losing their husbands to war or abandonment. In 1986 the Refugee Policy Group reported that two-thirds of all families in the three largest camps in Ethiopia were headed by women, 50% of these women were widows, and 50% were "grass-widows"–women whose husbands were alive but have been fighting or have abandoned them. Figures are similar among Indochinese refugees: 80% of the Khmer households along the Thai-Cambodian border are headed by women. Being the head of a household is particularly demanding since refugees tend to have large families. Among refugees in Somalia, the average household consists of 8-9 persons, including 2-3 adults and 5-6 children (Taft, 1987).

Although women make up the majority of the refugee population, most of the programs and services offered to refugees are developed, implemented, and administered by men. The result is a system which has little regard for the majority of its users. Most refugees live in unsanitary conditions where epidemics and disease are common, water supplies are contaminated, and food resources are insufficient. For a variety of reasons however, women face particular hazards as a result of their gender, and in 1980 the United Nations High Commissioner for Refugees designated women a "particularly vulnerable segment" of the refugee population.

The following is a summary of the problems which refugee women encounter, both abroad and in the U.S., and some recommendations through which the international community and service providers can begin to address these issues.

THE EXPERIENCE OF RAPE AMONG REFUGEES

One of the most serious risks for refugee women, one which is rarely addressed by the health community, is the problem of rape and sexual violence. Refugee women, many of whom are widowed or young, have few structures to protect them. Women and girls who flee their home countries to escape violence are vulnerable to sexual violence along every step of their journey. Although this problem is no secret, the international community has failed to develop adequate measures to protect refugee women from such violence.

DURING WAR

The rape of women and girls during war is nothing new. Rape is a military strategy used to humiliate and demoralize an opponent. Since women are a symbol of honor in many societies, they are not the only targets of rape. "In conflicts between different political or religious groups, sexual violence against women has been used as a means of aggression towards an entire section of the community or as a means of acquiring information about the activities and location of family members" (Siemens, 1988, p.22). As a form of torture, men are often forced to watch while their wives or daughters are raped. In such circumstances the humiliation of the woman and helplessness of the man are the desired results. It is often as a result or in fear of such torture that refugees flee from their countries.[2]

DURING FLIGHT

Escaping their home countries, however, in no way means escaping brutality. Refugee women are subject to sexual violence and abduction at every step of their escape, and are particularly vulnerable when crossing borders to seek asylum.[3]

It has been noted that approximately 44% of the "boat people" who arrive in Thailand are subjected to attacks by pirates (Taft, 1987, p.29). During these attacks women and girls are the primary target and are often subjected to multiple rapes and/or abduction. The women are usually taken off the boat and forced onto a pirate boat. They are raped repeatedly, often by gangs of men, and are then pushed overboard and left to die. If they are not pushed into the water, they may be passed on to another pirate boat for the same torture or taken to an island where they are forced to work as slaves.

Although pirate attacks in the waters of Southeast Asia are the most well-known and well-documented incidences of violence against refugees, refugee women's vulnerability has made them targets of similar violence along escape routes in many other parts of the world. At a workshop on Women Refugee Claimants held in Toronto, Canada on April 4, 1990, attorney Ninette Kelley provided some harrowing statistics concerning women refugees. In Djibouti it is estimated that virtually every female refugee who enters the country is raped at the border and at other times during her stay. In Mozambique, refugee women are often raped and abducted by Renamo guerrillas who take the refugees back across the border to act as slaves for the rebels (1990, p.5). In Central America,

cayottes–men who are paid large sums of money to assist refugees in fleeing from their homelands into neighboring countries–often rape women and girls in exchange for safe passage (Wali, 1990).

Recently, the forced prostitution of Afghans has gained international attention. According to Wali, the women and girls are forcibly abducted at the border of Afghanistan and Pakistan and sold to Pakistani brothels. The tragedy is that most of these women are unaware of their fate, and think that they are being escorted to refugee camps. Since many are unaccompanied young girls and widows, no one is left to protect them or to monitor their movement (or disappearance). Although no official studies have been undertaken, it is estimated that thousands of Afghan women have been sold into prostitution in Pakistan. During their visit to Pakistan in 1990, a delegation of the Women's Commission for Refugee Women and Children based in New York heard numerous stories confirming this outrage (Wali, 1991).

As remarkable as it may seem, thousands of women survive such circumstances. They arrive at refugee camps expecting to find safety.

IN CAMPS

While refugee camps exist to provide a safe haven for those who have fled for their lives, they often provide little protection, and in fact can be dangerous places. Refugee women are often subjected to violence by the very people who are supposed to protect them. Stories of rape by camp authorities and military guards are common. Without protection, women are often unable to leave their camp homes to collect food or other necessities (Kelley, 1989).

In addition, refugee women in camps are often sexually harassed by men from their own ethnic communities.[4] The system of assistance in some regions encourages this condition. Relief agencies in Southeast Asia distribute food to women and children only, assuming that men will receive supplies through their families. Often men steal food from the women, and in some cases threaten or sexually harass a woman, and then vow to protect her (or stop the harassment) in exchange for food (Brahm, Soland & Swain, 1986, p.5). In certain Moslem regions such as Pakistan, where women are traditionally forbidden from having contact with male strangers, refugee women can receive food and services only through familiar male intermediaries (Taft, 1987). In such cases the survival of a woman and her children may depend on her ability to bargain with the men. Once again, refugee women are left vulnerable to sexual harassment and violence, and have no choice but to submit in order to survive.

IMPLICATIONS

The raping of refugee women is planned and unusually brutal. While most victims of rape in the United States are attacked by an individual man, many refugee women are gang raped or raped repeatedly, often for days at a time. They are often in situations where they witness additional rape, either the rape of a family member, friend or acquaintance. For many of these women, rape is the most frightening and humiliating experience they have lived through and carries serious implications. The experience is so traumatic that many victims consider or commit suicide.

In addition to the emotional trauma of being victimized, many women sustain physical injuries, contract venereal disease or become pregnant as a result of rape. Health resources are limited; most relief workers have not been trained to recognize either the physical or emotional symptoms of rape trauma. Even if they do identify victims, refugee workers are scarce and few have the training to recognize such problems and approach them in a culturally appropriate manner. Women usually receive no medical or emotional treatment and are left to confront the issue alone, without the traditional support structures of home.

This situation is worsened by the religious and cultural attitudes surrounding rape. Most refugee cultures relegate women to a submissive role where they are considered the property of men. For women who come from Asian or African cultures their value as women is based on their virginity, and goodness is synonymous with purity. Because women are considered to be the property and "honor" of men, rape victims are considered "ruined" and are ostracized by their communities. They lose all value in society and are rejected by their families who feel they have been shamed. This is further supported by the Islamic, Buddhist, Taoist and Catholic religious philosophies in which "fate" plays a large role. Rape victims of Muslim faith believe that rape is a punishment for some sin which they have committed. Similarly, Buddhist rape victims attribute their tragedy to "karma," or destiny. Thus, in addition to being ostracized by their families and societies, refugee women who have been raped often blame themselves for their tragedy and feel ruined and ashamed (Wali, 1990).

In response to these feelings, women refugees who have been raped are often unwilling to disclose their experiences to refugee workers. "A Winnipeg study found that over 1/2 of rape victims and 94% of other sexual assault victims didn't tell any professional outsider about the assault" (Pope, 1990, p.8). Instead of seeking help for rape, often women will approach a relief worker with psychosomatic symptoms related to her experience. Symptoms of post-traumatic stress are similar to those of non-

refugee rape victims. They include depression, loss of appetite, anger, a sense of hopelessness about the future, fear of strangers, or feeling dirty. Much like other rape victims, a woman may be deeply disturbed if left alone, or she may feel uncomfortable having other people near her. The worker must be trained to recognize the situation and respond appropriately. Understanding such cultures and religions and their ideologies regarding rape is central to the role of the refugee worker in determining appropriate intervention mechanisms.

Like rape victims, male refugees also suffer psychological damage which can affect their emotional well being. Once out of immediate danger a refugee man may be angry for the horrible crimes which he has witnessed and feel guilty for having been unable to live up to his expected role in society and protect himself and his family. After witnessing massive episodes of pain and torture, the psychology of violence may numb him and, like children who have been abused, make him more likely to resort to violence himself.

RESETTLEMENT

Upon resettlement refugee families face a variety of challenges adapting to a new society. For most refugees this is their first experience in an industrialized country, and traditional social patterns often become confused. The stress involved in this process is further elevated by the psychological and emotional traumas which result from the refugee experience. Refugee men often feel victimized by their experience and feel that they have failed in their obligation to protect their families. This vulnerability, compounded by the frustration of resettlement, often leads refugee men to resort to domestic violence to recover power and control.

ESCAPE TRAUMA

Once a refugee family has successfully arrived in the United States to resettle, the physical and psychological impact of its past experience can hinder its move to self-sufficiency. The term "escape trauma" has been used to refer to the scars left from the experience of fleeing one's country to escape persecution.

Refugees are likely to have lost children. A survey conducted in a Cambodian refugee camp in Thailand found that 80% of women in the camp had lost three-fourths of their children in the past four years. In

Sudan, a survey conducted in March 1985 found that 34% of the women in one camp had lost at least one child in the previous four months (Berry, 1985, p.36). As most refugees have lost family members through war, persecution or illness (i.e., epidemics, starvation), they often arrive with feelings of guilt at having survived when so many others did not. This guilt only compounds the grief traditionally associated with the loss of loved ones.

Refugees also face the distress of leaving their homeland with no knowledge of when, or if, they will be able to return. They often try to recreate their culture in countries of resettlement, waiting for the time when they can return home. This is particularly painful if a refugee has lost social status once held among their community. In addition, most refugees have lost the traditional support system of their extended family, and are forced to find new emotional support.

Escape trauma can be serious, and can be responsible for a range of symptoms including severe depression, anger, hostility, nightmares, insomnia, and waking memories (Mollica, 1988). Thus, memories of destruction and devastation can be both long-lasting and debilitating.

ECONOMIC OBSTACLES

In addition to psychological obstacles, most refugees arrive in the United States with little or no money and depend on limited federal assistance. Like millions of others, they can easily become caught in the cycle of poverty. A shortage of affordable housing and childcare, and lack of accessible health care are just a few of the economical obstacles refugees face. Employment is often hard to find, especially with language barriers. Even refugees who were well educated are often forced to resort to unskilled labor in order to survive.

SOCIAL ROLES

In their home countries women were responsible for the family and home, and primarily associated with other females or male family members. In countries of resettlement where it is difficult to support a family, women are often forced to work outside of the home for the first time. This is the most common alteration in family roles and responsibilities, and can create tension within the family. Especially for a male refugee who is unemployed or underemployed and whose sense of identity is

already challenged, his wife's offer to work may be perceived as an indication that she is ignoring familial responsibilities and has lost respect for her traditional role.

Women are also confused by their new roles. Suddenly they are responsible for a job in addition to their caretaking responsibilities. When refugees arrive in the United States, they are often amazed at the independence of American women. Everyday chores like going to the grocery store often entail learning new skills including using public transportation and dealing with family finances. These activities are made more difficult since refugees are expected to learn a new language.

Contributing to this frustration, many women report feeling anxious about their children's assimilation into American culture. While refugee women are left isolated and struggling, their children are swept into the school system and immersed into a culture which their parents find unfamiliar. Refugee women feel their culture and traditions slipping away. Some complain that their children spend too much time watching T.V. and not enough time helping their parents or grandparents. To them, this is a sign that traditional methods of respect are being eroded by laziness and materialism. They also worry that their children will become involved in drugs and/or violence. The cultures from which most refugee families in the United States originate place great importance on families and familial responsibility. Refugee women often feel that they have lost control over their children, the only thing of importance still intact in their lives.

IMPLICATIONS

With the confusion of social roles and frustration of economic difficulties, the stress of resettlement can be overwhelming. For refugee men, the experience of war and escape leave psychological anxieties regarding their personal strength and sense of identity. Men who have been victims of persecution, especially men whose wives or daughters have been raped in their presence, feel a sense of failure at not having been able to protect themselves or their loved ones. Often termed "heightened male vulnerability," this feeling is exacerbated by resettlement trauma and financial struggles. In response, many refugee men turn to domestic violence as a way to reestablish control and increase their power.

This is especially true if a woman has been raped. Men are more likely to abuse a rape victim as her status in the community has been lost. Women also blame themselves and feel that they do not have the rights

or resources to oppose such treatment.Refugee women who have relocated in the United States are not aware that domestic violence is illegal. Although the problem is widespread, it is often kept a secret as the result of the social, political, and religious customs in which refugees have been raised. Women believe that domestic problems are private and should not be discussed with non-familial members. Since such silence exists, refugee women feel isolated and are unaware of how widespread domestic violence actually is.

If a woman does discuss her situation, it is usually in private with either a female relative or close friend. However, these women are unaware of available resources and act more as support than as a solution. A refugee woman may consult a community leader such as a priest, or an elder who is widely respected. In most cases, however, these leaders also feel that domestic violence is a private matter and advise the woman to respect her husband and obey his decisions. Thus the women are left with no other choice but to return home and accept the situation.

Although awareness regarding the seriousness of domestic violence among refugee communities has increased and community groups have been created to assist refugee victims of domestic violence, there is a general reluctance to approach such help as it carries negative connotations. In his article on post traumatic therapy, Richard Mollica discusses several reasons why refugees avoid mental health resources. In many societies, especially among Southeast Asian cultures, there is an extreme stigma associated with mental illness. "Many refugees" explains Mollica, "associate shame and humiliation with their perceived need to seek help for a 'broken mind or spirit'" (1988, p.300-1). Apart from cultural barriers, many refugees have a well-founded fear of endangering their immigration status. Both within the camps, where refugees who have been diagnosed with major psychiatric disorders are denied resettlement, and in the United States, where refugees fear that their citizenship may be threatened, refugees avoid any association with mental health resources which they feel could threaten their immigration status (Mollica, 1988).

Refugee women are the pillars of their large families, caring for both children and the elderly. When a woman's health is endangered, the health of her entire family suffers making the move to self-sufficiency difficult. Both rape trauma and domestic violence have side effects which threaten the women's ability to care for their families. Refugee women's health and protection needs must be addressed not only by the international community, but by mainstream health practitioners in countries of resettlement as well.

RECOMMENDATIONS

In order to appropriately address these issues, a comprehensive plan must be developed. Protection overseas, and domestic violence in the United State must addressed by both international and domestic health providers.

OVERSEAS

Although refugee women who have been victims of rape are unlikely to discuss their experiences, there are steps which service providers in the camps can undertake to identify rape victims. The first and most obvious sign that a woman has been raped is physical injury. Even if she seeks help for a physical injury, however, a refugee woman is not likely to disclose what happened. Service workers must be trained and willing to recognize the symptoms and devise an appropriate response.

In an innovative chapter written for a soon-to-be-published handbook addressed to workers inside refugee camps, Sima Wali (RefWID) outlines some methods for recognizing victims of rape. Once a refugee worker recognizes that a woman is suffering from symptoms of rape trauma, background records can help to clarify her situation. For example, if a refugee's records indicate that she crossed the South China Sea in a boat and she appears to be suffering from rape trauma, it is likely that she was either raped or witnessed the raping of others by pirates.

As a result of the cultural attitudes toward rape, women who have been victims are often ostracized by their communities. When families learn that a woman has been raped, she is considered worthless and a source of humiliation for them. Listening closely to community members can reveal whether a woman is being ostracized or isolated by her community. This is a good sign that she has been raped.

Through this handbook, it is hoped that workers will get a better idea of how to recognize rape victims. Once a refugee worker has established that a woman has been raped, the chapter gives some suggestions on how to respond appropriately. Most important, considering the ostracism placed upon victims by their community, Wali stresses confidentiality. The victim must feel that she can trust the worker to keep her ordeal a secret. It must always be assumed that the woman has not revealed her experience to anyone, as refugee victims often keep rape a secret from their families, even their husbands (Wali, 1990).

IN COUNTRIES OF RESETTLEMENT

In many cases, mainstream health workers are the first people to come in contact with refugee victims of domestic violence. Like refugees in camps, refugees in the U.S. often seek medical help for psychosomatic symptoms related to rape or resettlement trauma. In order to effectively address the problem of domestic violence within refugee communities, mainstream workers need to be able to identify such symptoms and know what resources are available to the victims. Training about refugees and their experience is essential for health workers, especially those working near areas with high refugee populations. As with refugee workers in camps, the first step is education. Training on domestic violence should be incorporated into mainstream programs such as medical and nursing schools, and those likely to come in contact with refugees should be given additional training in dealing with refugee families.

Bicultural workers must be incorporated to assist mainstream (non-ethnic) service providers. Refugee women are more likely to be open and comfortable with women of their own ethnicity. This can also help address language barriers between refugee women and counselors.

In response to this need, RefWID has developed and tested a model for training refugee and mainstream service providers. RefWID has conducted training sessions across the country focused on teaching service providers culturally appropriate methods to working with refugee victims of domestic violence. The sessions are based on a manual entitled "Understanding Domestic Violence within US Refugee Communities" which is the outcome of the development and successful pilot test of a training program (Richie, 1988).

Educating the refugee community is another important step towards reducing domestic violence. Unless victims use available resources, intervention mechanisms cannot work. Successful education depends both on the ability of refugee women to speak out about their situation, and the willingness of the community to listen. Refugee women must be given the resources for empowerment, including leadership and organizational training, to enable them to better communicate with each other. By breaking their isolation, refugee women will realize that domestic violence is a widespread problem which together they can defeat.

Since refugee women often approach community leaders for advice, these leaders must also be educated about domestic violence and rape trauma. Whether they are religious leaders such as monks, or social lead-

ers such as respected elders, their attitudes toward domestic violence and rape trauma set a precedent for the rest of the community. Leaders must be educated through culturally appropriate methods concerning the legal aspects of domestic violence, and the implications of traditional attitudes which place blame on the victim.

CONCLUSION

Domestic violence is a problem which can impair any family's self-sufficiency. For refugee families who have escaped terrifying and life-threatening situations to resettle in a new country, the trauma of escape and stress involved in acculturation can provoke the use of violence against women.

Refugee women who have resettled in the United States are a resourceful element commonly overlooked. They flee their homes amidst gunfire, cross dangerous and life-threatening borders, and provide care for large families within a system which provides minimal assistance. Their mere survival is a symbol of their strength. Despite suffering horrifying problems, refugee women demonstrate remarkable capabilities in creating better lives for themselves and their families.

Refugee women are the emotional support of their families and communities. They are responsible for educating and transmitting culture to their children, and caring for children and the elderly. When these women are consulted and included in the development process, their families move more quickly and successfully into economic and social self-sufficiency.

The health of refugee women must be addressed by the international community, as well as by health care professionals in the United States. A comprehensive method must be undertaken in order to effectively address issues of protection for refugee women. (1) The international community must be willing to dedicate the necessary attention and resources to prevent sexual violence. (2) Mainstream health and social workers in the United States must be trained to recognize and appropriately address the issue of domestic violence among refugee families. (3) Refugee women need access to the skills and resources necessary for self-empowerment. Only when health care professionals recognize their role in extending services to refugee women can comprehensive programs be developed.

NOTES

1. According to the 1961 Convention relating to the Status of Refugees, a refugee is any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to return to that country.

2. Although rape is often used as a form of torture, it is not included in the 1961 Convention relating to the status of refugees. As a result, women who are in danger of sexual assault/rape cannot claim that they are in fear of being tortured, and may not be granted refugee status.

3. Refugees, by definition, are outside their country of origin. The issue of rape, however, is relevant for displaced persons, or those who have fled similar situations but are still inside of their own borders, as well.

4. Although it is rarely discussed as an issue of protection, refugee women are also faced with rape by their own husbands.

REFERENCES

Berry, A. (1985). Declaration on training. Proceedings, *Refugee women: A round table organized by the United Nations High Commissioner for Refugees* (pp. 36-38). Geneva, Switzerland.

Brahm, S., Soland, M., & Swain, P. (January 1986). *The rape experience of refugee women resettled in the United States.* Manuscript, Washington, D.C.: RefWID.

Kelley, N. (April 1990). Refugee women and protection: criteria and practices for determining refugee status. *Summary of comments made at the CRDD working group on women refugee claimants: Training workshop for members, RHO's and legal services.* Toronto, Canada.

Kelley, N. (1989). *Working with refugee women: A practical guide.* Geneva: United Nations High Commissioner for Refugees.

Mollica, R. (1988). The trauma story: The psychiatric care of refugee survivors of violence and torture. In F. Ochberg (Ed.), *Post-traumatic therapy and victims of violence* (pp. 295-314). New York: Brunner/Mazel.

Overhagen, M. van. (1990). Introduction. M. van den Engel (Ed.), *VENA Newsletter: Refugee and displaced women* (V2, n2, pp. 3-6). The Netherlands.

Pope, L. (April 1990). Refugee protection and determination: Women claimants. *Summary of comments made at the CRDD working group on women refugee claimants: Training workshop for members, RHO's and legal services.* Toronto, Canada.

Richie, B. (1988). *Understanding family violence within U.S. refugee communities.* Washington, D.C.: RefWID.

Siemens, M. (1988). Protection of refugee women. *Refugees* (pp. 21-22). Geneva: United Nations High Commissioner for Refugees.

Taft, J. (1987). *Issues and options for refugee women in developing countries.* Washington, D.C.: Refugee Policy Group.

Wali, S. (1990). *Female refugee victims of sexual violence: Rape trauma and its impact on refugee resettlement.* Manuscript, Washington, D.C.: RefWID.

Wali, S. (1991). *Rape trauma and its effect on refugee women and their communities.* Manuscript, Washington, D.C.: RefWID.